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Developing person-centred care: addressing contextual challenges through practice development

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Abstract

Developing person-centred care is not a one-time event; rather it requires a sustained commitment from organisations to the ongoing facilitation of developments, a commitment both in clinical teams and across organizations. Contextual factors pose the greatest challenge to person-centredness and the development of cultures that can sustain person-centred care. We will begin with a general comment on 'context' and its meaning before exploring three particular factors that influence the practice context, namely, workplace culture, learning culture, and the physical environment. Next we explore a particular approach to developing person-centred care through emancipatory practice development. We highlight the importance of facilitation through emancipatory practice development programmes and describe how person-centred care can be developed through the presentation of a case study that illustrates the principles and processes of emancipatory practice development as well as the outcomes achieved. We conclude with an application to clinical practice. A key consideration for all organisations in the development of person-centred care is to move from what we suggest are 'person-centred moments' (individual, ad hoc experiences of person-centredness) to 'person-centred care' as an underpinning culture of teams and organisations.

Keywords

Person-centredness, person-centred care, nursing, learning culture, organisational culture, care environment, facilitation, practice development, emancipatory change, context, change management, evidence-based practice, evaluation

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Developing Person-Centred Care: Addressing Contextual Challenges Through Practice Development

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Abstract

Developing person-centred care is not a one-time event; rather it requires a sustained commitment from organisations to the ongoing facilitation of developments, a commitment both in clinical teams and across organizations. Contextual factors pose the greatest challenge to person-centredness and the development of cultures that can sustain person-centred care. We will begin with a general comment on 'context' and its meaning before exploring three particular factors that influence the practice context, namely, workplace culture, learning culture, and the physical environment. Next we explore a particular approach to developing person-centred care through emancipatory practice development. We highlight the importance of facilitation through emancipatory practice development programmes and describe how person-centred care can be developed through the presentation of a case study that illustrates the principles and processes of emancipatory practice development as well as the outcomes achieved. We conclude with an application to clinical practice. A key consideration for all organisations in the development of person-centred care is to move from what we suggest are 'person-centred moments' (individual, ad hoc experiences of person-centredness) to 'person-centred care' as an underpinning culture of teams and organisations.

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The purpose of this article is to identify and discuss issues to consider in the development of person-centred care. We define person-centred care as an approach to practice that is established through the formation and fostering of therapeutic relationships between all care providers, patients, and others significant to them. Person-centred care is underpinned by values of respect for persons, individual right to self determination, mutual respect, and understanding (McCormack, Dewing, Breslin, Tobin et al., 2010). Whilst many readers will be familiar with the term 'patient-centred care,' we use the term 'person-centred care' as we believe it more explicitly reflects the application of the above humanistic values to all persons engaged in caring encounters, including patients, clients, families/carers, nurses, and other members of the multidisciplinary team.

In the article we will focus on contextual factors as these factors have the potential to greatly enhance or hinder the way that person-centredness evolves in teams and on clinical units. We will also discuss approaches to the facilitation of person-centred care through the methodology of emancipatory practice development. This methodology emphasises the active facilitation of increased effectiveness of person-centred care through the application of new knowledge and skills that individuals and teams develop via active learning in practice (Manley, McCormack, & Wilson, 2008). Next we will offer a case study of the development of person-centred care in order to illustrate emancipatory practice development in action and the changes that were brought about in order to move towards more person-centred cultures of care. We will conclude by summarizing how this approach can be applied in practice.

Contextual Factors and the Development of Person-Centred Care

McCormack and McCance (2010) have suggested that many nurses experience 'person-centred moments,' i.e. particular times in practice when everything seems to come together and the outcome feels satisfying and

rewarding. We all have memories of those moments and stories to tell of their significance to us as nurses - be it a significant event with a patient, a meaningful moment of support offered by a colleague, feedback from a leader that was intentional and empowering, or an expression of thanks from a family member that made the everydayness of practice seem all worthwhile. Such 'person-centred moments' may have triggered the question, "Why can't it be like this all the time?". Indeed, this same question is one that we found arising from our research with patients. In our analysis of patient and resident stories (McCance, Gribben, McCormack, & Mitchell, 2010; McCormack, Dewing, Breslin, Tobin et al., 2010) we found continuous evidence of what can be described as 'practice contradictions,' i.e. simultaneous moments of person-centred and non-person-centred practice.

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We acknowledge that we do not work in a state of utopia, and that everyday practice is challenging, often stressful, sometimes chaotic, and largely unpredictable. Yet it is important to consider that person-centred moments, such as those between one nurse and one patient, must be increased to become an everyday cultural pattern or norm for all. Thus, it must further be considered how person-centred moments can be transformed into 'person-centred cultures' of practice where satisfaction, involvement, and feelings of well being for patients and nurses are commonplace. To do this requires a particular commitment to the ongoing development of practice, paying attention to rigorous processes, the continuous evaluation of person-centred effectiveness, the celebration of successes (Manley, McCormack, Wilson, & Thoms, 2008), and engagement by managers (Dewing, 2008a) and other key stakeholders.

In the development of a framework for person-centred nursing, McCormack and McCance (2010) identified a range of attributes of practice contexts that impacted on the operationalisation of person-centred care. Of particular significance were workplace culture, learning culture, and the physical environment. A number of studies have identified these attributes of the work environment as being particularly significant in creating environments that enable person-centred care to be realised (Brown & McCormack, 2011; Dewar & Mackay, 2010; McCance et al., 2010; Wilson, McCormack, & Ives, 2005). Each will be described below.

Workplace Culture

Culture in health and social care has been studied extensively over the past 20 years (Davies, Nutley, & Mannion, 2000; Ferlie & Shortell, 2001; Scott, Mannion, Davies, & Marshall, 2003). The international drive (particularly over the past 15 years) to 'modernise' healthcare systems has led to a significant focus on the impact of culture on the clinical effectiveness of staff and service-user experiences of health and social care. This focus has been subsumed under a quality umbrella (O'Reilly, Courtney, & Edwards, 2007). We would argue that much of what is known about organisational culture in other types of organisations has yet to be effectively applied to healthcare.

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Manley (2000) suggested that it is the culture of wards and departments (workplaces) that patients, residents, and staff experience every day. Manley added that the characteristics of these cultures need to go beyond 'organisational artefacts,' e.g. visible products, such as language, technology, clothing/uniforms, and forms of address. Cultures are also characterised by shared values, team effectiveness, a commitment to continuous learning and improvement, and transformational leadership. Coeling and Simms (1993), Adams and Bond (1997), and Wilson, McCormack, and Ives (2005) have argued that because culture has been found to vary between workplaces within the same organisation, there is a need to understand the culture of each individual workplace prior to implementing innovations or developments.

Learning Culture

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Learning cultures are productive cultures, characterized by their ability to tolerate productive tensions, learn from mistakes, support and enable innovation, maximize individual potential, and understand the interrelationship between team/system processes and the effectiveness of outcomes achieved (Kaye & Jordan-Evans, 2005; Manley, Titchen, & Hardy, 2009; Titchen & Binnie, 1995). A learning culture is a culture in which nurses view their work as exciting and revitalising, offering them the prospect for both personal and professional growth. Creating an environment in which learning occurs takes account of the ward/unit atmosphere, the context (setting) within which nursing takes place, and the process used to enable learning to occur. Senge (2006) has suggested that sustained learning only occurs in a supportive context in which learning is viewed as an integrated component of practice. Numerous studies have identified the value of investing in learning (staff education in the work setting) so as to develop the effectiveness of the workplace culture (Clarke, 2001; McCormack, Dewing, Breslin, Coyne-Nevin et al., 2010; Platzer, Blake, & Ashford, 2000). This learning can facilitate an exciting workplace environment in which challenge is part of everyday practice and ensure that learning extends beyond the boundaries of the clinical unit (Platzer et al., 2000).

It is important to recognize that the values of mutuality, collegiality, and care that are espoused in mission statements and organizational frameworks are often not easily realised by staff in practice. Despite a large amount of literature addressing teams, team-effectiveness, and team culture, dysfunctional team relationships and dissonance between espoused and lived management and leadership values continue to exist in nursing and healthcare (Brown & McCormack, 2006; Wilson et al., 2005). The key goal in the development of a positive learning culture is to recognize and overcome individual, group, and organizational barriers in order to move towards an effective culture (Hoff, Pohl, & Bartfield, 2004) and to overcome the features of workplaces that nurture hierarchical management and horizontal violence (Brown & McCormack, 2011).

Contemporary efforts regarding the development of 'models of care' that have the patient at the centre and the nurse positioned to facilitate autonomous decision making can be seen as attempts to re-orientate the design of healthcare services towards ones that are based on patient, family, and staff experiences (New South Wales Health Department, n.d.). In addition, the ongoing research into organizations known as 'Magnet Hospitals' has illustrated the organizational conditions that are necessary for staff to feel empowered. Magnet hospitals have been associated with attributes that have been positively linked to nursing staff outcomes (Aiken & Sloan, 1997a, 1997b; Aiken, Sloane, & Lake, 1997).

The Physical Environment

Arneill and Frasca-Beaulieu (2003; 163) have written:

> ...a beautiful health care unit is not necessarily one in which patients feel nurtured and supported. A patient who is frightened, lonely, and isolated from family and friends is not likely to notice the carefully decorated surroundings. It is only when the architecture and interior design works in concert with other … components that the environment can help a caring staff help a patient feel less lonely and isolated.

The physical environment of care has for a long time been recognised as having a significant impact on the care experiences and patient outcomes. Indeed, Florence Nightingale placed a major emphasis on the quality and cleanliness of the environment and viewed this as being critical to patient recovery. However, as Arneill and Frasca-Beaulieu (2003) asserted, the physical environment needs to work in concert with the cultural values in care teams and the ways of working that enable person-centredness to be realised. In this respect, two aspects of the physical environment need to be attended to, namely, the built environment and the aesthetic environment.

Most hospitals and healthcare facilities have been designed and built with 'clinical efficiency,' and not person-centredness, in mind. The tyranny of infection control and safety agendas in many countries are adding to depersonalisation; for example, no flowers, plants, or paintings are permitted in some clinical settings. However, considerable efforts are being made to ensure that new healthcare facility designs adopt a more person-centred approach. Because not all patients and staff can expect facilities that are designed with person-centredness explicitly in mind, there is a need to consider how existing environments can be enhanced.

In one such initiative the King's Fund (London) has developed the 'Enhancing the Healing Environment Programme (EHE).' The aim of this programme is to encourage and enable local teams in hospitals to work in partnership with patients and families to improve the environment in which they deliver care. The programme provides small grants to multidisciplinary teams to help them work together to change the physical environments in which patient care is delivered. An evaluation of the initially funded programme (Lowson, Beale, Kelly, & Hadfield, 2006) has demonstrated both therapeutic and economic benefits of such environments, as well as positive experiences among participants. Changes have included an integrated interior design and artwork project undertaken as part of a major refurbishment of the emergency department and integrated art and design projects in clinic waiting spaces at major London Hospitals. The EHE principles have been adopted by many hospitals throughout the United Kingdom. The outcomes from the work have included evidence of the impact of aesthetics on patient well being, such as reduction in violent incidents in a mental health unit reported by Dooher and Kozlowski (2010). Dooher and Kozlowski have stated that "designs that adhere to EHE principles provide the opportunity for service users and patients to make choices … conducive to privacy, social interaction or therapeutic engagement, made easier by the flexibility of the environment" (p17).

Similar design initiatives have occurred in residential care settings, particularly for older people and people living with dementia. Contemporary care homes aim to be more reflective of a home environment and to focus on an overall 'domestic size and style,' including open-plan kitchen/dining/living spaces; single ensuite rooms with personal belongings and furniture, and reduction or elimination of obvious 'hospital like' structures, such as nurses stations and offices, as the heart of the care setting (Dementia Services Development Centre, 2007; Drew, 2005; Kane, Lun, Cutler, Degenholtz, & Tzy-Chyi, 2007)

The aesthetic environment is also a key consideration. Considerable developments have taken place in ensuring that the environments are aesthetically pleasing and also promote healing, nurturing, care, belonging, and sensory engagement. These are important attributes for both patient and staff revitalisation. The strategic placement of art (pictures, sculptures, and other instillations) for sensory and emotional stimulation; the use of different colours, lights, sounds, and smells to promote relaxation; and the integration of performance art with healthcare practice have all become more commonplace. Evidence from maternity services (Chang, Chen, & Huang, 2008), people with dementia (Hannemann, 2006; Kontos, Mitchell, Mistry, & Ballon, 2010) and people with head injuries (Elliott, 2008) has demonstrated the positive, therapeutic effects of integrating health and the arts.

Developing person-centred care requires a sustained commitment to the facilitation of multiple aspects of culture change in clinical settings and organisations. However, despite many examples of well-intentioned projects, it continues to be the case that embedding person-centredness in team, unit, and organisational cultures is a challenge, and indeed

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often seems 'elusive' in the everyday (chaotic) world of practice. For some, the whole agenda of person-centred care is merely a buzz term or a process of 'naming that which already exists,' for example by asking "We are doing it anyway aren't we?". Yet others may have identified issues and ideas that stimulate new ways of thinking about practice and are wondering,"How do I move towards this way of nursing?". Both of these positions pose challenges to the facilitation of person-centred care developments. What is clear is that for person-centred care to be realised, a sustained commitment to its development and maintenance in practice is required from organisations. We contend that the organizational change methodology of emancipatory practice development offers such an approach.

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Developing Person-Centred Care Through Emancipatory Practice Development

The term practice development is widely used within the nursing profession in the United Kingdom, Ireland, and Australia. Practice development is defined as:

> … a continuous process of developing person-centred cultures. It is enabled by facilitators who authentically engage with individuals and teams to blend personal qualities and creative imagination with practice skills and practice wisdom. The learning that occurs brings about transformations of individual and team practices. This is sustained by embedding both processes and outcomes in corporate strategy. (Manley, McCormack, & Wilson, 2008, p. 9)

This definition highlights the key components of practice development, namely that it is a facilitated activity that focuses on helping individual clinicians and teams to understand the context in which they work and the characteristics of that context that may prevent them from practising effectively. Practice development emphasises the central place of learning through everyday practice, what we have come to describe as 'active learning.'

Active learning (Dewing, 2008b& 2009; McCormack, Dewing, Breslin, Tobin et al., 2010) is an approach for in-depth learning that draws on and integrates numerous learning methods. It is based in and derives from personal, emotionally connected experiences of practitioners and patients in the workplace. Being open to, engaging with personal experience through critical reflection, learning from experience (seeing and doing) with others, and evaluation are central activities in this approach.

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Active learning draws on many activities including multiple intelligences, critical reflection, learning from self, and also conversations and shared experiences with others, all of which enable facilitation of change in the workplace. Central to active learning is both the translation of learning into practice so that the practitioner's own practice is experienced differently and the enabling or facilitating of active learning with others. Active learning takes knowledge, in its many forms, and looks at how it can become (emotionally) meaningful for individuals and teams. Thus it expands on what is known about knowledge translation and diffusion activity. Everyday doing and taken-for-granted aspects and patterns of practice are critical markers for active learning. Active-learning methods can be used to explore language, values and beliefs, the environment and whom it privileges, signage, routines and rituals, team work, and decision making, to name a few areas of exploration. Enabling staff to learn how to evaluate the processes and outcomes of practice and to demonstrate the impact of practice development for patients, families, and staff is also a core activity.

Closely connected to the moments of person-centredness in practice described at the beginning of the paper, van der Zijpp and Dewing (2009) have suggested that 'moments of movement' are experienced by practitioners and facilitators when they are able to implement learning that enables transformation to take place. The following case study is used to illustrate some of the core principles, purposes, processes, and outcomes of emancipatory practice development work in the context of developing person-centred care.

A Case Study of Person-Centred Care Using Emancipatory Practice Development

This section will describe the background and context, aims and objectives, methodology, and findings of a case study using emancipatory practice development. It will illustrate how this program enhanced patient-centredness.

Background and Context

The Older Persons National Practice Development Programme in the Republic of Ireland (McCormack, Dewing, Breslin, Coyne-Nevin et al., 2010; McCormack, Dewing, Breslin, Tobin et al., 2010) was a national, two-year, practice-development programme (2007-2009). It was influenced by broader international, theoretical, and methodological advancements in practice development, and in particular built on the findings of the first systematic review of practice development (McCormack, Wright, Dewer, Harvey, & Ballintine, 2007). In this review of theoretical and methodological developments the authors identified nine key issues that needed to be addressed in order for practice development to have a desired impact. The programme was managed and delivered by The University of Ulster. The funding for the programme came from the National Council for the Professional

Development of Nursing & Midwifery and six participating Nursing and Midwifery Planning and Development Units (NMPDUs). The purpose of the National Council for the Professional Development of Nursing & Midwifery is to promote and develop the professional roles of nurses and midwives, in partnership with stakeholders, in order to support the delivery of quality nursing and midwifery care. There are eight NMPDUs in the Republic of Ireland. The NMPDU is an integral component of the Health Service Executive, coordinating continuing professional development, practice development, quality improvement, and workforce developments in the Irish Health Service. The budget was managed by the NMPDUs.

Aims and Objectives

The overall aims of the programme were to: (a) implement a framework for person-centred practice for older people across multiple settings in Ireland through a collaborative facilitation model, and (b) to carry out an evaluation of the processes and outcomes. The definition of person-centred care presented in the introduction to this paper was used to shape the work of the programme. The objectives of the programme were to:

1. Coordinate a programme of work that can replicate effective practice development processes in care of older peoples settings
2. Prepare participants, local facilitators, and their directors and managers to recognise the attributes of person-centred cultures for older people and key practice development and management interventions needed to achieve the culture (thus embedding person-centred care within organisations)
3. Develop person-centred cultures in participating practice settings
4. Systematically measure or evaluate outcomes of practice for older people
5. Further test a model of person-centred practice in long-term care/rehabilitation settings and develop it as a multi-professional model
6. Utilise a participant-generated data set to inform the development and outcomes of person-centred practice
7. Enable local NMPDU facilitators to work with shared principles, models, methods, and processes in practice development work across older people's services (**McCormack, Dewing, Breslin, Tobin et al., 2010**)

Methodology

The programme methodology was that of emancipatory practice development (Manley & McCormack, 2004) as discussed earlier and underpinned by a specific, person-centred, practice framework (McCormack & McCance, 2006). Within the emancipatory practice development methodology, and for the aims of this programme, particular emphasis was placed on evaluation and on learning. Below we will discuss the program structure and processes, ethical approval, and the evaluation of this program.

Programme Structure and Processes. Eighteen residential units for older people were involved in the programme. Practice development programme groups were established. The groups represented staff from different areas within the units and different grades, i.e. Clinical Nurse Mangers, Staff Nurses, and Health Care Assistants, along with Housekeeping, Catering, and Administration Staff.The participants from the sites met with the internal facilitator from within their unit and the external facilitator from the NMPDU for a formal programme and skills development day every six weeks. As the first year progressed a range of interim meetings and discussion groups were established within the workplace in between these every-six-week programs. In Year 2 these session evolved into project-working and action plan-implementation groups. The programme had a number of visible activities that took place on a regular basis. Overarching these 'events' the programme activities principally involved the following:

- developing an understanding of what work/practice development involves and the competence and confidence to role model the processes to be used becoming familiar with the Person-Centred Framework and Practice Development Model which were the frameworks used for the programme and for achieving the above understandings
- facilitating an understanding of workplace culture and change processes
- holding awareness-raising activities for different staff groups, older people, and families in the programme sites
- establishing a shared vision using values clarification exercises and involving the residents/patients' families/carers and all staff within their work place
- participating in active learning in the workplace
- using structured reflection
- learning facilitation skills
- developing greater appreciation of and skills for effective group and team work, and
- working with evaluation methods.

Ethical approval. Ethical approval for the programme of work was received from six individual regional ethics committees. The university facilitators developed a 'core protocol' and supporting letters, information sheets, and guidance notes. They then worked with each NMPDU facilitator to contextualise the core materials to each regional ethics committee as each committee had different requirements. The protocol took account of development activities, individual site-evaluation activities, and the overall programme evaluation framework.

Evaluation Methods. The processes and outcomes from the practice development programme were evaluated within a framework of cooperative inquiry (Heron & Reason, 2008). The notes from the programme days detailing learning evaluations and feedback to directors were collated and analysed for evidence of progression. The evaluation of this specific part of the programme identified a variety of active-learning activities that were utilised. In addition, a number of evaluation instruments were used. These instruments included The Workplace Culture Critical Analysis Tool (WCCAT) by McCormack, Henderson, Wilson, and Wright (2009); The Person Centred Nursing

Index (PCNI) and Person Centred Caring Index (PCCI) by Slater (2006) and Slater and McCormack (2007); and User Narratives by Hsu and McCormack (2010). These instruments were developed as components of previous research and development in person-centred practice and have established their validity and reliability.

The project leaders, lead facilitators, and project participants all acted as co-researchers in the collection and analysis of the data. Thus this programme had the added benefit of developing evidence-gathering and research skills among participants. Data were collected at three time points during the programme. Data collected using the PCNI, PCCI, WCCAT, and user narratives were analysed at a local level to inform the development of action plans and collectively at a national level both to inform the effectiveness of processes and also to assess outcome achievement across the programme as a whole. The WCCAT and user narrative data were analysed using a participatory approach with programme participants, programme facilitators, and programme leaders. The PCNI and PCCI data were analysed after each round of data collection using SPSS. The items that comprised each factor were summed and a mean score calculated for each factor. The identity of each participant remained anonymous at each time point, although this did limit comparison across times at the organisational level. Descriptive statistics were calculated for each of the factors contained in the instruments at each time point. A one-way analysis of variance was used to compare the mean scores on each construct for the total sample across the three time points.

All NMPDU facilitators received a summarised report of findings for their participating sites. These reports were shared with programme participants and the findings used to further inform ongoing action planning at a local level. In addition, the data across all sites were collated into single reports at each data collection period in order to inform the overall evaluation of the programme and to inform progress with achieving the outcome of developing person-centred cultures in the participating sites.

Summary of Findings

The personal and professional growth for individuals across different roles and within the healthcare teams was evident in the analysis of the programme day notes. Active-learning activities were found to be acceptable to the participants and utilised throughout the programme days and in practice. The acceptability and usability of active learning across all the sites and throughout all the days was high, further indicating its usefulness.

The data analysis suggested that staff had shifted their views from one of seeing 'technical' aspects of nursing as caring to that of recognizing the 'non-technical' aspects of caring as being even more important.

Significant progress was made in achieving numerous attributes of a person-centred culture. These outcomes are summarized here but are reported in detail in McCormack, Dewing, Breslin, Coyne-Nevin et al. (2010). These changes relate to the 'pre-requisites' of person-centred practice within the person-centred practice framework. These prerequisites focus on the attributes of the care worker; they include: being professionally competent, having developed interpersonal skills, being committed to the job, being able to demonstrate clarity of beliefs and values, and knowing self. These changes are significant in terms of developing a person-centred culture. Statistically significant changes ($p>0.01 - 0.05$) included:

- Preparation for the role
- Staff support
- Knowledge of treatment decisions
- Communication and support
- Career development
- Role satisfaction
- Staffing and resources
- Commitment to the setting
- Workload
- Intention to stay in role

There was also a change in the nurses' 'perceptions of caring.' The data analysis suggested that staff had shifted their views from one of seeing 'technical' aspects of nursing as caring to that of recognizing the 'non-technical' aspects of caring as being even more important. The development of person-centred cultures is not a 'one-off' or 'one-time' event but instead is an ongoing and continuous process. Thus further development of staff continues to be needed.

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In the Year 1 observation data there were as many poor practice examples as there were good practices. In the Year 2 data there were appreciably fewer examples of poor practice, demonstrating a change in culture and supporting the findings of the PCNI and PCCI. For residents and families the data demonstrated important qualitative changes in care practices and these changes were particularly evidenced in residents' narratives. The combined narrative and observation data illustrated developments in four key areas of the care experiences for

older people and their families.

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Hope and hopelessness. The data showed a shift towards increased hopefulness in the way that residents were cared for, as noted in an improvement in the range of activities available for residents, their involvement in decision making, and the quality of engagements between staff and residents. One resident shared, *"The hopelessness has been taken away from me. You have got reassurance wherever you go with staff and patients … and you seem to have a purpose …."* However, hopelessness among residents continued to be an issue and further work is needed in this area as noted in the following comment:

> Time is long, boredom sometimes. I'd love to get home but there would be no one there. Just to get out would be great – great to get away from it. I will go out in the weather when the weather is good. I go down in the lift but my husband used to come down four times a week before he died. He is a terrible loss. The girls are working and live off away from here. I'd like to get out while I'm able …No, I don't feel I have a say in how things are done here – No say, no, just get on with it ….

Choice. The data demonstrated that residents were provided with a greater range and number of choices. Specific activities, such as resident and family groups, have been initiated and established in the majority of settings to encourage more choices for residents as noted below:

> It would be good if people could remember or know when films like the westerns are on because all of the men like them. They were films you would have gone to see in the picture houses – John Wayne is great. You can talk for hours about them. A keg of Guinness would be good too – I do not like the cans. He [pointing to another resident] has one when a friend or sister comes into visit.

Belonging and connectedness. Compared with Year 1 data, there was evidence of staff 'knowing the person' in a more meaningful way:

> I get good care here and the staff take a genuine interest in me. I love music and really enjoyed 'scriocht' [traditional Irish storytelling and poetry activity] last year. It reminded me of being at home with my friends and neighbours … I am very thankful to those who care for me and try to improve life for me in all their different ways.

A range of activities has now been initiated to enable greater knowing of residents as persons with 'histories.' These histories were noted to have had an impact on the quality and quantity of meaningful engagement with residents. Considerable attention has been paid to improving the environment in many of the participating sites, and this has been viewed positively:

...there was evidence of staff 'knowing the person' in a more meaningful way.

> There are nice paintings and artwork on the walls … it is a warm day so the windows are open which leaves a pleasant breeze. There is toast being made for the residents, the smell is pleasant and fills the room. The residents seem happy to see each other and greet each other warmly as the two staff members do. There is a good 'banter' – a happy atmosphere. There are magazines on the coffee tables – some of them are out of date. There are bowls of fruit available. When each resident enters the room they are greeted warmly, often by other residents but the staff are friendly and cheerful too. (observation note)

Meaningful relationships. The attention paid to overt demonstrations of being more person-centred, such as language, team-work, reducing ritual and routine, facilitating more choice, intentionality, and the development of meaningful relationships, have had a positive impact on resident experience:

> The care worker is helping a resident out of bed. She is working in a calm way and giving the resident lots of encouragement. The language she is using is very person-centred and is focused on the resident's needs – very respectful. (observation note)

An evaluation framework has now been introduced, one that can continue at a local, regional, or national level. This framework can support residential care inspection and regulation standards and processes, as well as other quality initiatives nationally across 'older peoples' services. The programme described in this article has enabled the facilitators to work with shared principles, models, methods, and processes in practice development work; and these can be continued. The data informed the development of local action plans and has been used to demonstrate outcomes in person-centred care across the sites over three time periods.

Application to Practice

Developing person-centred cultures is not a

In this paper we have explored some of the contextual factors that can impact on the development of person-centred cultures. Developing person-centred cultures is not a one-person job; it requires commitment from a whole team. We recognize that person-centred cultures are not achieved

one-person job; it requires commitment from a whole team.

from one-off change events. Rather once a commitment to developing person-cultures is made, teams need to be able to see 'bite-sized,' tangible changes to maintain commitment, enthusiasm, and morale. Engaging in activities, such as active learning and observations of practice, enable teams to 'stand back' from the everydayness of practice and to see if person-centred approaches really exist. Further, such activities help identify strategies that can enable more effective teamwork, better time management, and more productive staff relationships, all of which enable a shift from 'person-centred moments' to a culture of person-centred practice.

Conclusion

In this paper we have highlighted the complex, contextual issues that challenge the existence of person-centred care in organisations. The real challenge for all organisations is the movement from individual, 'person-centred moments' to 'person-centred cultures.' It is clearly evident from the international literature that this cannot happen by relying on the individual motivation of practitioners. Instead the change requires a sustained commitment to facilitated culture change with teams and across organisations. Whilst we have been able to bring about effective facilitation approaches with clinical teams, the challenge of engaging managers in these same processes continues. It is our contention that if managers reinforce only the importance of short-term changes, without including person-centred considerations, then person-centred cultures will not be achieved. Expert facilitation at all levels of an organization, along with an integrated approach to active learning within an emancipatory intent, appear to have the potential to achieve such a culture change.

The real challenge for all organisations is the movement from individual, 'person-centred moments' to 'person-centred cultures.'

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